APPENDIX D

VISION COVERAGE

I. Enrollment Classifications

Vision coverage for a primary enrollee may include coverage for eligible secondary enrollees as defined in the Program.

II. Description of Benefits

Vision benefits will be payable, subject to the conditions herein, if an enrollee incurs a covered vision expense.

III. Definitions

As used herein:

A. "ophthalmologist" means any licensed doctor of medicine or osteopathy legally qualified to practice medicine, including the diagnosis, treatment, and prescribing of lenses related to conditions of the eye.

B. "optometrist" means any person legally licensed to practice optometry as defined by the laws of the state in which the service is rendered.

C. "optician" means one who makes or sells eyeglasses prescribed by an ophthalmologist or optometrist to cure or correct defects in the eyes, and grinds the lenses or has them ground according to prescription, fits them into a frame, and adjusts the frame to fit the face.

D. "participating provider" means an ophthalmologist, optometrist, or optician who has signed an agreement with the carrier covering reimbursement, quality, service standards and other terms and conditions connected with providing covered vision services to enrollees.

E. "nonparticipating provider" means an ophthalmologist, optometrist, or optician who has not signed an agreement with the carrier covering reimbursement, quality, service standards and other terms and conditions connected with providing covered vision services to enrollees.

F. "contact lenses" means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted directly to the enrollee's eyes.

G. "lenses" means ophthalmic corrective lenses, as prescribed by an ophthalmologist or optometrist, to be fitted into a frame.

H. "frame" means a standard eyeglass frame into which two lenses are fitted.

I. "covered vision expense" means the reasonable and customary charges for vision care services and materials, as described in Section IV., when provided by ophthalmologists, optometrists, and opticians for each enrollee.

J. "corrective eye surgery" means a surgical procedure used to alter the cornea or shape/surface of the eye in order to improve visual acuity, correct vision conditions such as myopia, hyperopia, or astigmatism and reduce or eliminate the reliance on eyewear. Such surgeries can include, but are not necessarily limited to, Laser- assisted In-Situ Keratomileusis (LASIK), PhotoRefractive Keratectomy (PRK) and Radial Keratotomy (RK).

K. "reasonable and customary charge" as used in this Appendix also refers to scheduled or other contracted amounts of payment used by carriers with participating provider arrangements. The carrier is responsible for determining the appropriate reasonable and customary charge for a given provider and service or material, and such determination shall be conclusive.

IV. Benefits

Benefits will be paid for the covered vision expenses described in A., B., and C. below, less any copayment as described in D. below.

A. Vision Examinations:

1. Refraction, including case history, coordinating measurements, and tests;

2. The prescription of glasses where indicated; and

3. Examination by an ophthalmologist, upon referral by an optometrist, within 60 days of a vision examination by the optometrist.

B. Lenses and Frames:

When lenses are prescribed by an ophthalmologist or optometrist, the necessary materials and professional services connected with the ordering, preparation, fitting, and adjusting of:

1. Lenses (single vision, bifocals, trifocals, lenticular). If the enrollee selects lenses, the size of which results in an additional charge, only the reasonable and customary charge for normal size lenses of the same material and prescription will be considered a covered vision expense. If the enrollee selects photochromic lenses or lenses with a tint other than Number 1 or Number 2, only the reasonable and customary charge for clear lenses of the same material and prescription will be considered a covered vision expense.

2. Contact lenses following cataract surgery, or when visual acuity cannot be corrected to 20/70 in the better eye except by their use, or when medically necessary due to keratoconus, irregular astigmatism or irregular corneal curvature. If contact lenses are prescribed for any other reason, $80 is the maximum amount that will be considered a covered vision expense

3. Frames. If frames are obtained from a participating provider, the enrollee may make a selection from the display shown by the participating provider and there will be no out-of-pocket expense to the enrollee other than as described under "copayments". However, if the selection at the participating provider is not from the display shown, or if the enrollee obtains frames from a nonparticipating provider, $16 is the maximum amount that will be considered a covered vision expense until January 1, 2004 and $24 thereafter.

C. Corrective Eye Surgery: Effective January 1, 2004, corrective eye surgery performed by an ophthalmologist will become a covered service. Coverage includes any related pre and post-surgical professional services, facility expense and medically necessary supplies. Coverage is subject to the following provisions:

1. An enrollee may not receive benefits for both corrective eye surgery and for frames and/or lenses (including contact lenses) in the same calendar year;

2. Upon proof of payment to the corrective eye surgery provider, the carrier will reimburse the primary enrollee for covered expense, up to the lesser of the charges or the maximum benefit of $295.00 in any four (4) year period; and

3. An enrollee receiving benefits for corrective eye surgery in any one calendar year will be ineligible for lens (including contact lens) and/or frame benefits for that year and three (3) subsequent years. For example, an enrollee undergoing corrective eye surgery in 2004 would be eligible for lens and/or frame benefits in 2008. Such enrollees will be eligible for benefits for an annual exam, and will have access to the participating provider fee schedule for non-covered services and for lenses and/or frames for which no benefits are payable.

D. Copayments:

For each enrollee, there is a $7 copayment applicable to the covered vision expense for each vision examination and a $10 copayment for the combined covered vision expenses for lenses, contact lenses, and frames. The total copayment for each enrollee, during a calendar year, will not exceed $17.

V. Frequency Limitations

For each enrollee, there are the following limitations on the frequency with which charges for certain services and materials will be considered covered vision expenses:

Vision Examination	-	Once during a calendar year, except as provided in Section IV.A.3.
Lenses	-	Once during a calendar year, except as provided in Section IV.C.
Frames	-	Once during two consecutive calendar years, except as provided in Section IV.C.

The limitations on lenses, contact lenses, and frames apply whether or not they are a replacement of lost, stolen, or broken lenses, contact lenses, or frames.

VI. Exclusions

A. Any lenses which do not require a prescription;

B. Medical or surgical treatment of the eye, except as provided in Section IV.C.;

C. Drugs or any other medication;

D. Procedures determined by the carrier to be special or unusual, such as, but not limited to, orthoptics, vision training, subnormal vision aids, aniseikonic lenses, and tonography;

E. Vision examinations or materials furnished for any condition, disease, ailment, or injury arising out of or in the course of employment; and

F. Vision examinations performed and lenses and frames ordered:

1. before the enrollee became covered for this coverage;

2. after the termination of the enrollee's coverage; or

3. to the extent that they are obtained without cost to the enrollee.

VII. Vision Network

A. The carrier has implemented a network of participating providers who agree to accept reimbursement according to a schedule for the covered vision services and materials described in Section IV.A. and B. without enrollee copayments.

B. If an enrollee uses a participating provider to obtain covered services, the carrier will reimburse the provider without enrollee copayment as specified below:

1. the scheduled amount (which shall be payment in full) for eye examinations, normal-size clear, Number 1 or Number 2 tinted lenses; and medically necessary contact lenses (see Section IV.B.1. and 2.);

2. the scheduled amount (which is payment in full) of $24 for eyeglass frames with a retail value of $80 or less. If an eyeglass frame with a retail value greater than $80 is selected, the enrollee will be responsible for the discounted price

(participating providers discount frames with the retail cost in excess of $80), less $24; and

3. the scheduled amount of $65 for contact lenses, which do not meet the criteria in Section IV.B.2. The enrollee will be responsible for any amount greater than $80.

C. If an enrollee resides 25 miles or less from a participating provider but obtains covered services from a non-participating provider (other than an ophthalmologist), the carrier will reimburse the enrollee the scheduled amounts. The enrollee will be responsible for paying the provider, including any remaining balance. Reimbursement to the enrollee for covered services received from non-participating ophthalmologists will be made at the reasonable and customary amount, less the enrollee copayment (see Section IV.D.).

D. If an enrollee resides more than 25 miles from a participating provider and obtains covered services from a non-participating provider (including an ophthalmologist), the carrier will reimburse the enrollee in accordance with Section IV. above.